

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045086

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 1562

FILED NOV 18 1963

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST. CHARLES	
b. CITY (If outside corporate limits, give TOWNSHIP only) ST. CHARLES		c. CITY OR TOWN ST. CHARLES	
Length of stay in 1b 2 DAYS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		d. STREET ADDRESS (If outside, give location) RT. 1	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First KELLY Middle RAYE Last WOOLDRIDGE			4. DATE OF DEATH Month NOV. Day 13 Year 1963		
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-7-63	9. AGE (last birthday) Months 5 Days 5 Hours 5 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
11. BIRTHPLACE (City and state or country) ST. CHARLES, MO			12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME RAY WOOLDRIDGE			13b. MOTHER'S MAIDEN NAME JUDITH CAROL BURKE		
14. NAME OF HUSBAND OR WIFE RAY WOOLDRIDGE, ST. CHARLES, MO			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. RAY WOOLDRIDGE, ST. CHARLES, MO			17. INFORMANT Address		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial meningitis DUE TO (b) Sepsis DUE TO (c) Intra ventricular hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour 7:05 a.m. pm Month, Day, Year 11-12-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bush		20f. CITY, TOWN, OR LOCATION ST. CHARLES		20g. COUNTY MISSOURI	
21. I attended the deceased from 11-12-63 to 11-12-63 and last saw him alive on 11-12-63 Death occurred at 7:05 pm on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Prinster Baue		22b. ADDRESS 207 N. FIFTH		22c. DATE SIGNED 11-13-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 14 NOV. 1963		23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY	
23d. LOCATION (City, town, or county) ST. CHARLES		23e. STATE MISSOURI		23f. REGISTRAR'S SIGNATURE Mabel Zumwalt	
24. FUNERAL DIRECTOR PRINSTER BAUE F.H.		25. DATE RECD. BY LOCAL REG. NOV 14-1963		26. REGISTRAR'S SIGNATURE Mabel Zumwalt	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frederick W. Bane

Licensed Embalmer No. 4607

P. O. Address St. E. Raleigh 1140

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.